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	085015	A. BUILDING _____ B. WING _____	03/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEAFORD CENTER	1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from March 21, 2017 through March 28, 2017. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 110. The Stage 2 sample totaled 39 (thirty nine) residents. Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; DON- Director of Nursing; ADON- Assistant Director of Nursing; RN - Registered Nurse; LPN- Licensed Practical Nurse; CNA - Certified Nurse's Aide; NP - Nurse Practitioner; AP/PA-physician designee; Physician Order Sheet (POS) - monthly report of active physician orders; RNAC - Registered Nurse Assessment Coordinator; UM - Unit Manager; MAR-medication administration record; eMAR-electronic MAR; TAR-treatment administration record; PRN-as needed; Antipsychotic - medication to treat psychosis; Anxiety - feeling worried, nervous or restless; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15. 13-15: Cognitively intact 08-12: Moderately impaired 00-07: Severe impairment	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/19/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		

Blanchable - skin loses redness/turns white when pressed with finger (better than non-blanchable);
cm (centimeter) - a metric measurement of length; 1 centimeter = 0.39 inches;
Cognition - mental processes or thinking;
Continence - control of bladder and bowel function;
Cerebrovascular disease - a disease of the blood vessels that supply the brain that can lead to a stroke;
Depakote - anti-seizure medication used as a mood stabilizer;
Depression - mood disorder with feelings of sadness;
Diazepam - medication for anxiety and tension and as a muscle relaxation;
e.g. - for example;
EMR - electronic medical record;
eMAR - electronic medication administration record;
Hydrocolloid dressing - dressing that forms a gel with water/fluid;
Incontinence - loss of control of bladder and/or bowel function;
Intact - skin is unbroken;
Ischemia - supply lack of blood to body tissue or organ;
Lateral - outer side;
Maceration - softening and whitening of skin by soaking in fluids;
Minimum Data Set (MDS)- An assessment tool used to assess nursing home residents;
MediHoney - gel treatment to remove dead tissue;
Melatonin - supplement given for sleep;
Milligram (mg) - metric unit of weight, mass;
Obsessive-Compulsive Disorder (OCD) - mental disorder with need to repeat behaviors / rituals;
Offloading/Offload - removal of pressure from an

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F 000	Continued From page 2	F 000		

area;
PRN - as needed;
PPD-skin test for tuberculosis [infection of the lungs]
Pain Scale - rating of pain severity on a 0 to 10 scale with 0 meaning no pain and 10 meaning the worst pain;
Shear/Shearing Force - friction with reduced blood flow to the tissue under the skin from sliding down in, or being pulled across, the bed;
PU-Pressure ulcer-sore area of skin that develops when the blood supply to it is cut off due to pressure;
****
Stages (severity) of pressure ulcers (PUs):
Stage I (1) - intact red skin often over a boney area that does not turn white/light when pressed;
Stage II (2) - blister or shallow open sore with red/pink color;
Stage III (3) - open sore that goes into the tissue under below the skin. How deep it is depends on the amount of tissue under the skin;
Stage IV (4) - open sore so deep that muscle, tendon or bone can be seen/felt;
Unstageable - actual depth of the ulcer cannot be determined due to the presence of slough (yellow, tan, gray, green or brown soft dead tissue) and/or eschar (hard dead tissue that is tan, brown or black. Eschar is worse than slough;
Suspected Deep Tissue Injury (sDTI) - Purple or maroon intact skin or blood-filled blister. May start as tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than surrounding tissue;
Psychosis - loss of contact/touch with reality;
Prealbumin-carrier of protein in the blood;
Psychotherapeutic medications - medications for anxiety, depression, or other mental disorders;

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F 000	Continued From page 3 Psychotropic (drugs) - medications capable of affecting the mind, emotions and behavior; Quetiapine Fumarate - antipsychotic medication for severe mental disorders which works by regulating certain chemicals in the brain; Sertraline - a medication for depression, panic and anxiety; Slough - yellow, tan, gray, green or brown dead tissue; Total Dependence - full staff performance every time activity performed; Undermining - skin edges have lost contact with underlying tissue; Vitamin B12-vitamin with key role in brain and nervous system function; Wound bed - bottom of a wound; pre-before; post-after; =equals; X - times.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 157		5/19/17

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F 157	Continued From page 4 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide notification to the responsible party following a fall and transfer to emergency services for one (R221) out of 39 sampled residents. Findings include:	F 157	A. No corrective action can be accomplished for this resident as resident no longer resides at this facility. B. Records of residents who have fallen or were transferred to the hospital were reviewed to ensure the responsible parties	

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F 157	Continued From page 5 Review of R221's clinical record revealed; 9/2/16 - A progress note documented that R221 was "transferred to the hospital for an unplanned evaluation and treatment via ambulance .... physician notified. Patient was found on the floor unresponsive. Physician called, 911 called, report called to hospital." 9/2/16 - An incident report documented "CNA went to check on residents and found R221 on the floor unresponsive, CNA got the nurse. Physician called, emergency room called with report." Responsible party notified "no". During an interview on 3/28/17 at 11:55 AM with E3 (RN) UM on R221's unit it was confirmed there was no evidence of notification to the responsible party of R221's fall and transfer to the emergency room. The facility failed to provide notification to the responsible party for R221, when on 9/3/16 R221 was found non-responsive and transferred to the hospital. These findings were reviewed with E1 (NHA) and E2 [DON] on 3/28/17 at 2:00 PM.	F 157	were notified. All responsible parties have been notified. C. A root cause analysis was conducted. The Charge nurse forgot to call the responsible party during and after the emergency. The policy for change in condition was reviewed by the Executive Team to ensure that notification of change is addressed. The Charge nurse and nursing staff were re-educated on our policy to notify the responsible party when there is a fall or a resident is transferred to the hospital (Attachment A). The education will be completed for all nurses. D. Falls and hospital transfers will be monitored to ensure proper notification of responsible parties are made 100% of the time (Attachment B). All falls and hospital transfers are monitored daily by unit managers/designee until 100% success is achieved over 3 consecutive evaluations. Then falls and hospital transfers will be monitored one more time, one month later. If we are 100% successful with this audit, we will conclude that we have successfully addressed the problem.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The	F 272		5/19/17

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F 272	Continued From page 6 assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.	F 272		

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F 272	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the accuracy and completeness of the comprehensive assessment for one (R72) out of 39 sampled residents. Findings include: Review of R72's clinical record revealed: 7/16/15 - Admission MDS Assessment revealed that the resident had obvious or likely cavity or broken natural teeth. 7/16/16 - Annual MDS Assessment's oral/dental section was blank and not completed. 12/20/16 - Dental consult documented R72 had 10 teeth in poor condition. The removal of remaining teeth and consideration of full dentures might be planned, but resident appears to be satisfied with present situation and stated he had no pain. 3/22/17 (12:00 PM) - Surveyor observation during the stage 1 of the survey discovered R72 was missing a left front tooth and resident denied mouth pain. During an interview with E6 (RNAC) on 3/27/17 at 10:55 AM to review the blank oral/dental section on the annual MDS, E6 said the data flows in from the nursing assessment. If the nursing assessment was not complete, then we don't use it. After reviewing the MDS in the computer E6 said "It says that section was not assessed." During an interview with E2 (DON) on 3/27/16 at 12:04 PM to discuss the blank oral/dental status of R72's annual MDS E2 stated the nursing	F 272	A. A modification of R72 s MDS was completed and resent. B. All residents MDS s were reviewed to ensure that the oral/dental section was completed. No corrective action was needed. C. A root cause analysis was conducted. User defined nursing assessments are completed after the due date or not at all.The nurses will be re-educated on timely completion of assessments (Attachment C). D. Dental assessments will be monitored to ensure the assessments are completed 100% of the time (Attachment D). All dental assessments will be monitored for completion daily by the unit managers until 100% success is achieved over 3 consecutive evaluations. Then dental assessments will be monitored for completion three times each week until 100% success is achieved over 3 consecutive evaluations. Then dental assessments will be monitored for completion once a week until success is achieved over 3 consecutive evaluations. Then dental assessments will be monitored for completion one more time, one month later. If we are 100% successful with this audit, we will conclude that we have successfully addressed the problem.	

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F 272	Continued From page 8 assessment "was done a day late." These findings were reviewed with E1 (NHA) and E2 on 3/28/17 at 2:00 PM.	F 272		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F 278		5/19/17

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F 278	Continued From page 9 (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the accurate assessment of pressure ulcers on a quarterly MDS assessment for one (R186) out of 39 sampled residents. Findings include: Cross Refer F314 Review of R186"s clinical record revealed: October 2016 - March 2017 - Skin Integrity Reports documented the following pressure injury ulcers during mid December 2016: - Right elbow: recorded as unstageable but wound bed 90-95% visible (12/12) and could have been staged. - Left Achilles: Stage 2 (12/9 and 12/16) - Left lateral ankle: Stage 2 (12/9 and 12/16) - Right buttock - left: recorded as unstageable but wound bed 100% visible (12/5) and should have been staged. - Right buttock - right: recorded as unstageable but wound bed 80% visible (12/12) and should have been staged. 12/16/16 - Quarterly MDS documented R186 had 5 unstageable pressure ulcers eventhough the left lateral ankle and left Achilles wounds were each a Stage 2. During an interview with E6 (RNAC) on 3/27/17 at 10:55 AM to review R186's pressure injury ulcers, E6 said she obtains staging information from the Skin Integrity Reports. E6 stated you "can never down grade." The surveyor explained that it was the numeric stage that cannot be downgraded	F 278	A. A modification of R186 s MDS was completed and resent. B. Records of residents with pressure ulcers were reviewed to ensure that the pressure ulcers were correctly staged. No corrective action was needed. C. A root cause analysis was conducted. There is inaccuracy by the nurses on the accurate , consistent staging of pressure ulcers on the Skin Integrity Report. The nurses will be re-educated on staging of pressure ulcers. (Attachment E). D. Skin Integrity Reports will be monitored to ensure the assessments are completed 100% of the time (Attachment F). All Skin Integrity Reports will be monitored for correct staging daily by the unit managers until 100% success is achieved over 3 consecutive evaluations. Then Skin Integrity Reports will be monitored for correct staging three times each week until 100% success is achieved over 3 consecutive evaluations. Then Skin Integrity Reports will be monitored for correct staging once a week until success is achieved over 3 consecutive evaluations. Then Skin Integrity Reports will be monitored for correct staging one more time, one month later. If we are 100% successful with this audit, we will conclude that we have successfully addressed the problem.	

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F 278	Continued From page 10 and not the unstageable rating. These findings were reviewed with E1 (NHA) and E2 (DON) on 3/28/27 at 2:00 PM.	F 278		
F 279 SS=E	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 279		5/19/17

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F 279	Continued From page 11 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and reviews of clinical records as well as other facility documentation, it was determined that the facility failed to develop care plans with measurable goals and failed to implement care plan interventions consistently for 3 (R2, R10, and R163) out of 39 sampled residents. Findings include: 1. Review of R2 's clinical record including the care plan revealed the following:	F 279	A. The care plans for alteration in comfort for residents R2, R10, and R163 have been reviewed including monitoring for non-verbal signs of pain and utilization of pain scale. B. Records of residents with care plans for alteration in comfort were reviewed to ensure that a measurable goal and acceptable level of pain are present. No corrective action was needed. C. A root cause analysis was conducted.	

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F 279	Continued From page 12 Focus Area: Resident exhibits or is at risk for alterations in comfort related to general discomfort initiated on 3/8/17 and revised the same day. Measurable Goal: Resident will achieve acceptable level of pain control x 100 days initiated on 3/8/17 and revised the same day. The goal was not measurable as written. R2's acceptable level of pain was not specified in the goal/objective. Interventions: Evaluate pain characteristics: quality,severity, location, precipitating/relieving factors. Utilize pain scale. R2 had other interventions as well which were all initiated on 3/8/17. March 2017 Medication Administration Record (eMAR) showed that pre (before) administration of medication level of pain nursing staff used a numerical scale and post (after) administration of the pain medication nursing staff documented that pain medications were effective. There was no consistent pain scale used to assess R2's acceptable pain level during the administration of pain medications. Progress notes from 3/14/17 through 3/28/17 also reflected that R2 received pain medications that were effective and/or ineffective. Nursing staff did document on one occasion that R2 had severe pain in his/her right arm. There was no consistent documentation regarding pre and post pain levels nor consistent documentation regarding the evaluation of R2's pain characteristics as listed in the care plan. 2. Review of R10's clinical record including the	F 279	The nurses were not following up the pain rating after pain medication administration, pain location not consistently charted, consistent use of chosen pain scale, and careplan not individualized for type/location of pain. The Pain Management policy was revised to include evaluation of pain level pre and post medication administration using pain scale. The nurses will be educated on the Pain Management policy. (Attachment G). D. As needed pain medication documentation will be monitored to ensure the documentation includes evaluation of pain characteristics and pre and post medication administration pain scale is present 100% of the time (Attachment H). All administered as needed pain medication documentation will be monitored for completion by the unit managers until 100% success is achieved over 3 consecutive evaluations. Then all administered as needed pain medication documentation will be monitored three times each week until 100% success is achieved over 3 consecutive evaluations. Then all administered as needed pain medication documentation will be monitored once a week until success is achieved over 3 consecutive evaluations. Then all administered as needed pain medication documentation will be monitored one more time, one month later. If we are 100% successful with this audit, we will conclude that we have successfully addressed the problem.	

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F 279	Continued From page 13 care plan revealed the following: Focus area: Resident exhibits or is at risk for alterations in comfort related to general discomfort initiated 3/3/17 and revised 3/7/17. Measurable Goal: Resident will achieve acceptable level of pain control x 100 days initiated 3/7/17 and revised the same day. The goal was not measurable as written. R10's acceptable level of pain was not specified in the goal/objective Interventions: Evaluate pain characteristics: quality, severity, location, precipitating/relieving factors. Utilize pain scale. There are other interventions listed as well which were all initiated 3/7/17. March 2017 eMAR showed that nursing staff documented the pre administration of medication level of pain using a numerical scale and post administration of the pain medications nursing staff used effective or ineffective. There was no consistent pain scale utilized by nursing staff to assess the resident's acceptable level of pain during and after administration of the as needed pain medication. There was no evidence in the clinical record that nursing staff were consistently evaluating R10's pain characteristics and precipitating factors when administering as needed pain medication. 3. Review of R163's clinical record including the care plan revealed the following: Focus Area: Resident exhibits or is at risk for alterations in comfort related to chronic back pain	F 279		

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F 279	Continued From page 14 initiated on 5/4/16 and revised the same day. Measurable Goal: Resident will achieve acceptable level of pain control x 100 days initiated 5/4/16 and revised on 2/28/17. The goal was not measurable as written. R163's acceptable level of pain was not specified in the goal/objective. Interventions: Evaluate pain characteristics: quality, severity, location, precipitating/relieving factors. Utilize pain scale initiated on 5/4/16 with no revision date. March 2017 eMAR showed that pre administration of medication level of pain nursing staff used a numerical scale and post administration of the pain medication nursing staff used effective. There was no consistent pain scale utilized by nursing staff to assess R163's acceptable level of pain during and after administration of the as needed pain medications. Progress notes reviewed from 3/12/17 through 3/25/17 documented that R163 received pain medication and that the medications were effective. There was no consistent documentation regarding pre and post pain levels nor consistent documentation regarding the evaluation of R163's pain characteristics as specified in the care plan. During an interview with the surveyor on 03/28/17 between 10:04 AM and 10:20 AM, E4 (ADON-UM) stated that she/he reviewed the "Pain Management" policy which reflected that staff are to use effective and ineffective to assess pain levels. The surveyor discussed care plans	F 279		

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F 279	Continued From page 15 for (R2, R10, and R163). The goals failed to specify acceptable levels of pain for the three residents and were not measurable as written. The surveyor informed E4 that nursing staff failed to implement the interventions regarding evaluation of and documentation of the pain characteristics each time as needed pain medications were administered. Additionally, nursing staff failed to consistently evaluate pain levels pre and post administration utilizing one pain scale. The above findings were discussed with E1 (NHA) and E2 at the exit conference on 3/28/17 at 2:00 PM.	F 279		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to accurately assess the severity of pressure injury wounds according to professional standards for one [R186] out of 39 residents sampled. Findings Include: Cross Refer F314 and F278 April, 2016 - The National Pressure Ulcer Advisory Panel revised the 2014 pressure ulcer	F 281	A. The Skin Integrity Report for resident R186 has been corrected. B. Records of residents with pressure ulcers were reviewed to ensure that the pressure ulcers were correctly staged. No corrective action was needed. C. A root cause analysis was conducted. The nurses were not accurately, consistently completing the Skin Integrity Report. The nurses will be re-educated on staging of pressure ulcers. (Attachment	4/19/17

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F 281	Continued From page 16 guidelines and changed pressure ulcer to pressure injury and added medical device and mucosal membrane pressure injuries. Staging the severity of wounds remained unchanged. A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The ability of the soft tissue to tolerate pressure and shear may also be affected by microclimate (temperature, moisture of area), nutrition, perfusion (blood supply), co-morbidities (disease, illness) and condition of the soft tissue. - Stage 1 Pressure Injury: Intact red skin often over a bony area that does not turn white / light (does not blanche) when pressed; which may appear differently in darkly pigmented skin. - Stage 2 Pressure Injury: Blister or shallow open sore with red/pink color. Deeper tissues/fat, granulation tissue, slough and eschar are not present. - Stage 3 Pressure Injury: Open sore that goes into the tissue under below the skin. How deep it is depends on the amount of tissue under the skin. Fat, granulation tissue and rolled edges are often present. Little slough and/or eschar may be visible but does not hide the extent of tissue loss. - Stage 4 Pressure Injury: Open sore so deep that muscle, tendons, ligaments, cartilage or bone can be seen. Rolled edges, undermining, tunneling often occur. Slough or eschar may be visible. - Unstageable: Actual depth of the ulcer cannot be determined due to the presence of slough (yellow, tan, gray, green or brown soft dead	F 281	E). D. Skin Integrity Reports will be monitored to ensure the assessments are completed 100% of the time (Attachment F). All Skin Integrity Reports will be monitored for correct staging daily by the unit managers until 100% success is achieved over 3 consecutive evaluations. Then Skin Integrity Reports will be monitored for correct staging three times each week until 100% success is achieved over 3 consecutive evaluations. Then Skin Integrity Reports will be monitored for correct staging once a week until success is achieved over 3 consecutive evaluations. Then Skin Integrity Reports will be monitored for correct staging one more time, one month later. If we are 100% successful with this audit, we will conclude that we have successfully addressed the problem.	

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F 281	Continued From page 17 tissue) and/or eschar (hard dead tissue that is tan, brown or black. Eschar is worse than slough. Once slough/eschar removed, a Stage 3 or 4 injury will be revealed. Stable eschar (i.e. dry, adherent, intact without redness or movement) on the heel or limb with impaired blood flow should not be softened or removed. - Deep Tissue Pressure Injury: Intact or non-intact deep red, maroon, purple discoloration that does not turn white/light when pressed or skin separation revealing a dark wound bed or blood filled blister. Pain and temperature change often appear before skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. - Medical Device Related Pressure Injury: Pressure from a medical device used for diagnostic or therapeutic purpose results in an injury that generally conforms to the pattern or shape of the device. The injury should be staged using the staging system. http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ Review of R186's clinical records revealed: 10/27/17 - Initial Nursing Assessment documentation included that the resident had no pressure injury ulcers but had incisions on the neck, left knee and right elbow along with assorted abrasions from the accident. 10/28/16 - Skin Integrity Report completed by E7 (Treatment Nurse) assessed that R186's right elbow had an unstageable pressure ulcer	F 281		

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F 281	Continued From page 18 measuring 3 cm x 2.5 cm. This pressure ulcer was not identified by the nurse admitting the resident to the facility. October 2016 - March 2017 - R186's Skin Integrity Reports revealed the following pressure wounds were identified as unstageable when the degree of tissue loss became visible after slough removal. - Right elbow: 90-95% wound bed visible on 12/12/16. - Right buttock (left wound): 100% wound bed visible on 12/5/16. - Right buttock (right wound): 80% wound bed visible on 12/12/16. During an interview with E7 on 3/24/17 at 12:30 PM when asked about wound staging for the buttock and elbow wounds, E7 stated the right buttock wound (right one) was a Stage 4 and the elbow was a stage 3 when after slough removal. When reviewing the Skin Integrity Report flowsheets E7 said that "once it is that [pointing to unstageable on the form] it can't be changed." Surveyor showed a copy of the sheet entitled FAQ: Pressure Ulcer Staging* Hints & Tips (*NPAUP Definitions) found in the facility's binder holding the active Skin Integrity Reports which documented "until enough slough and/or eschar is removed to expose the base of the wound, the true depth and therefore category / stage, cannot be determined." The severity of the buttock (right) and elbow was listed as unstageable through the 3/21/17 assessment. E7 said "I don't know what I was thinking when I wrote that." During an interview with E2 (DON) on 3/24/17 at 1:00 PM E2 was informed about admitting nurse not identifying the elbow pressure injury and the	F 281		

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F 281	Continued From page 19 staging issue after slough removal. E2 commented that there needs to be education, especially for the nurses admitting residents. The facility failed to identify a pressure ulcer on admission and failed to accurately assess three pressure injury wounds by assigning the appropriate stage after slough removal for R186. These findings were reviewed with E1 (NHA) and E2 on 3/28/17 at 2:00 PM.	F 281		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 309		5/19/17

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F 309	Continued From page 20 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that the facility failed to utilize the same pain scale when assessing pain levels before and after PRN pain medications were administered for four (R2, R9, R10 and R163) out of 39 sampled residents. In addition, the facility failed to consistently evaluate each residents' pain characteristics as specified in their care plans and/or implement nonpharmological interventions when appropriate. Findings include: Pain management standards were approved by the American Geriatrics Society in April 2002 which included: Appropriate assessment and management of pain; Assessment in a way that facilitates regular reassessment and follow-up; Same quantitative pain assessment scales should be used for initial and follow up assessment; Set standards for monitoring and intervention; and Collect data to monitor the effectiveness and appropriateness of pain management. Facility policy entitled Pain Management (effective 1/1/04 and last revised 11/28/16) included practice standards: If PRN medications are given, document on the back of the MAR or	F 309	A. The past pain documentation for residents R2, R9, R10, and R163 cannot be changed; however, current documentation includes non-pharmacological interventions, pain scale pre and post pain medication administration. B. Records of residents who receive as needed pain medication were reviewed to ensure that documentation includes non-pharmacological interventions, and a pain scale pre and post pain medication. Current documentation for these residents contains this information. C. A root cause analysis was conducted. The Pain Management policy was reviewed to include evaluation of and documentation of each time PRN pain medication is administered, non-pharmacological interventions, and evaluation of pain level pre and post medication administration using pain scale. The nurses will be educated on the Pain Management policy. (Attachment G). D. As needed pain medication documentation will be monitored to ensure the documentation includes	

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F 309	Continued From page 21 on the PRN Pain medication Flow sheet [in computer]. Patients receiving interventions for pain will be monitored for the effectiveness and side effects in providing pain relief. Document the following: effectiveness of PRN medications; ineffectiveness of routine or PRN medications including interventions, follow up and and physician/AP/PA notification; side effects, if present, and notification of physician/AP/PA. biopharmaceutical interventions and effectiveness. Facility printout of process for documentation of PRN medication administration in the MAR (11/29/16) included the following workflow: Enter supplementary documentation if required and a progress note for the reason for administration .... follow up progress notes will be written per policy...when the progress note screen appears enter the progress note and click on the appropriate button indicating if the medication was effective, ineffective or unknown. 1. Review of R2 's clinical record including the care plan revealed the following: The care plan had a goal for R 2 to achieve an acceptable level of pain control x 100 days initiated and revised on 3/8/17. Some interventions included but were not limited to evaluate pain characteristics: quality, severity, location, precipitating/relieving factors and utilize pain scale. The March 2017 MAR showed that pre (before) administration of medication level of pain nursing staff used a numerical scale on 11 occasions and post (after) the administration of the pain medication nursing staff used effective on 11	F 309	evaluation of non-pharmacological intervention, and pre and post medication administration pain scale is present 100% of the time (Attachment H). All administered PRN pain medication documentation will be monitored for completion by the unit managers/designee until 100% success is achieved over 3 consecutive evaluations. Then all administered as needed pain medication documentation will be monitored three times each week until 100% success is achieved over 3 consecutive evaluations. Then all administered as needed pain medication documentation will be monitored once a week until success is achieved over 3 consecutive evaluations. Then all administered as needed pain medication documentation will be monitored one more time, one month later. If we are 100% successful with this audit, we will conclude that we have successfully addressed the problem.	

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F 309	Continued From page 22 occasions. There was no consistent pain scale utilized by nursing staff to asses the resident's acceptable level of pain during and after administration of the as needed pain medication. Progress notes reviewed from 3/14/17 through 3/28/17 documented that R2 received pain medication on 8 occasions and nursing staff documented that the medication was effective. On one occasion (3/25/17) nursing staff documented that R2 had severe pain in his/her right arm. There was no consistent documentation regarding pre and post pain levels nor consistent evaluation of R2's pain characteristics as specified in R2's care plan. 2. Review of R10's clinical record including the care plan revealed the following: The care plan had a goal to achieve acceptable level of pain control x 100 days initiated and revised on 3/7/17. Some interventions included but were not limited to evaluate pain characteristics: quality, severity, location, precipitating/relieving factors and utilize pain scale. The March 2017 eMAR showed that nursing staff documented the pre administration of medication level of pain using a numerical scale on 28 occasions and post administration of the pain medication nursing staff used effective on 27 occasions and ineffective on one occasion. There was no consistent pain scale utilized by nursing staff to asses the resident's acceptable level of pain during and after administration of the as needed pain medication. During an interview with the surveyor on 03/27/17	F 309		

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F 309	Continued From page 23 at 12:01 PM, E10 stated that before R10 went to therapy I asked R10 if he/she was in pain. R10 took his/her as needed narcotic pain medication at 9:30 AM this morning. According to E10, R10's pain level prior to administration of the narcotic pain medication was an 8 using a scale of 0= no pain to 10= worst pain. 03/27/17 at approximately 12:33 PM, the surveyor observed R10 in his/her room having lunch. When asked R10 stated he/she was enjoying the fruit salad and cottage cheese and his/her level of pain was "okay." There was no evidence in the clinical record that nursing staff were consistently evaluating R10's pain characteristics and precipitating factors when administering as needed pain medication. 3. Review of R163's clinical record including the care plan revealed the following: A pain evaluation completed on 8/4/16 showed that R163's acceptable level of pain was a 4 (using a scale from 0=no pain to 10=worst pain) with interventions including repositioning and using heat. According to the evaluation the resident was satisfied with his/her current level of pain. A pain evaluation completed on 12/29/16 reflected that R163 had chronic leg pain ("pins and needles") which was worse on movement and an acceptable pain level was documented as 5. The care plan had a goal to achieve acceptable level of pain control x 100 days initiated and revised on 3/7/17. Some interventions included	F 309		

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F 309	Continued From page 24 but were not limited to evaluate pain characteristics: quality,severity, location, precipitating/relieving factors and utilize pain scale. March 2017 Medication Administration Record (MAR) showed that pre administration of medication level of pain nursing staff used a numerical scale on 18 occasions and post the administration of the as needed pain medication nursing staff used effective on 18 occasions. There was no consistent pain scale utilized by nursing staff to assess R163's acceptable level of pain during and after administration of the as needed pain medications. Progress notes reviewed from 3/12/17 through 3/25/17 documented that R163 received pain medication on 6 occasions and nursing staff documented that the medication was effective. There was no consistent documentation regarding pre and post pain levels nor consistent evaluation of R163's pain characteristics as specified in the care plan. During an interview with the surveyor on 03/27/17 at 8:45 AM, E8 (LPN) stated that R163 "usually can tell me what" his/her "pain level is, I just ask." E8 indicated that R163 had just stated the level of pain was a 4 and requested Tylenol (pain medication) not his/her as needed narcotic pain medication. 03/27/17 at 8:57 AM the surveyor interviewed the resident who was in bed. R163 indicated that his/her pain was not too bad and it was a 4 which was an acceptable level of pain based on the 12/29/17 pain evaluation. R163 indicated that he/she had just requested and received Tylenol	F 309		

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F 309	Continued From page 25 from the nurse. There was no documentation by nursing that nonpharmocological interventions were implemented prior to the administration of the Tylenol. R163 received his/her narcotic pain medication on at least 4 occasions in March 2017 when his/her pain level was 5 which was an acceptable level based on the 12/29/16 pain evaluation. There was no indication that nonpharmocological interventions were implemented prior to the administration of the narcotic pain medications. During an interview with the surveyor on 03/28/17 between 10:04 AM and 10:20 AM, E4 (ADON-UM) stated that she/he reviewed the "Pain Management" policy which reflected that staff are to use effective and ineffective to assess pain levels. Surveyor discussed care plans for (R2, R10, and R163). The goals fail to specify acceptable levels of pain for the three residents and were not measurable as written. The surveyor informed E4 that nursing staff failed to implement the interventions regarding evaluation of and documentation of the pain characteristics each time the as needed pain medications were administered. Additionally, nursing staff failed to consistently evaluate pain levels pre and post administration utilizing one pain scale. 4. Review of R9"s clinical record revealed: 6/11/08 - Care plan problem for alterations in comfort related to bilateral shoulder / leg pain and generalized discomfort (last revised 3/15/17) included the goal that resident will achieve acceptable level of pain control within one hour of medication. Interventions included: Evaluate pain characteristics: quality, severity, location, precipitating / relieving factors and utilize pain	F 309		

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F 309	Continued From page 26 scale. 9/21/16 - Physicians' orders included a pain medication to be given every 8 hours PRN. January - March 2017 - Review of eMARs and progress notes for PRN pain medication administrations discovered all 53 administrations lacked a pain rating severity after the PRN medication since they were recorded as effective and 31 out of 53 PRN administrations did not include the location of pain: - January: 14 out of 20 - February: 7 out of 15 - March: 10 out of 18 During an interview with E2 (DON) on 3/27/17 at 12:04 PM to discuss assessment of pain intensity after PRN pain medication, it was confirmed that nurses document effectiveness using words and not the pain rating scale. It was unclear if a request for the computer program to be revised to permit a pain score to be easily entered after PRN pain medication administration was considered. These findings were reviewed with E1 (NHA) and E2 at the exit conference on 3/28/17 at 2:00 PM.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 314		5/19/17

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F 314	Continued From page 27 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to accurately assess pressure ulcers, provide the necessary care and services to prevent the development of new pressure ulcers, and perform weekly assessment in one (R186) out of 39 sampled residents. Findings include: Review of R186's clinical record revealed: 10/27/16 - Admission to facility after a traumatic brain injury and multiple bone / spine fractures from a motorcycle accident. R186 arrived by ambulance from Baltimore (approximately 2 hour drive). 10/27/17 - Initial Nursing Assessment documentation included that the resident had no pressure ulcers but had incisions on the neck, left knee and right elbow along with assorted abrasions from the accident. R186 was incontinent of bowel and bladder and had a brace on the left lower leg, which had been broken in the accident. 10/28/16 - Physicians' orders included insertion of	F 314	Cross Referenced with F278 - Please see POC for F278	

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F 314	Continued From page 28 an indwelling urinary catheter. 10/28/16 - Care plan problem for risk of skin breakdown due to immobility included the following interventions: observe skin with ADL care daily and report abnormalities to physician; pressure redistribution surfaces to bed / chair; turn and reposition and skin check every 2 hours; utilize positioning devices to prevent pressure over bony prominences; float heels in bed. [There was nothing in the care plan about R186's left lower leg brace and its care and assessment.] 10/28/16 - Skin Integrity Report completed by E7 (Treatment Nurse) assessed that R186's right elbow had an unstageable pressure ulcer measuring 3 cm x 2.5 cm. [This pressure ulcer was not identified by the nurse admitting the resident to the facility.] 10/29/16 - Nutrition Note acknowledged the right elbow wound to determine nutrition needs with the tube feeding. October - November, 2016 - CNA flowsheet documented at the end of the shift that R186 was turned every 2 hours. On November 14 the flowsheet changed so that the CNA documented every 2 hours when turning occurred. Resident position (Right, Left, Back) not required. 11/3/16 - Admission MDS Assessment documented the resident was comatose and totally dependent on staff for bed mobility, transfer, and all ADLs. R186 was at high risk for the development of pressure ulcers and received continuous tube feeding for nutrition. The resident had two Stage 2 pressure injury ulcers (buttock) and one unstageable (elbow).	F 314		

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F 314	Continued From page 29 11/3/16 (10:00 PM) - Progress note documented R186 had developed two pressure wounds on right buttock measuring 3 cm x 2.2 cm x <0.1 cm and 1.8 cm x 2 cm x 0.1 cm. 11/4/16 (5:01 PM) - E7 staged the severity of the pressure ulcers as Stage 2 with treatment to cleanse with wound cleanser, apply skin prep to the surrounding skin then apply hydrocolloid dressing to open area. Change dressing every 5 days and PRN if compromised. 11/7/16 (12:26 PM) - Progress note documented R186 was turned "often." 11/8/16 (3:44 AM) - Progress Note documented "checked on patient several times thru out this shift." NP Note documented splint intact to left lower leg on November 7, 8, 11, 12, 15, 18 (2016). 11/8/16 - Skin Integrity Report documented R186's two right buttock pressure ulcers merged into one wound measuring 8.6 cm x 7 cm x 0.1 cm. 11/9/16 - Care plan problem for actual skin breakdown included the following additional interventions: monitor for signs of pain related to wound and wound care; weekly wound assessment to include measurement and description of wound status; MediHoney to right buttock (added 3/22/17 even though it was initiated 11/8/16). 11/10/16 - Physicians' order to float heels, turn and reposition every 2 hours and document which	F 314		

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F 314	Continued From page 30 side patient is on (Right, Left, Back). 11/10/16 - Nutrition Note acknowledged the buttock wounds when determining calorie and protein needs of the tube feeding. 11/10/16 (10:44 PM) - Progress note documented turn and reposition every 2 hours, float heels and document which side patient is on (Right, Left, Back) every 2 hours. Overlay working correctly. 11/11/16 (2:52 PM) - Progress note documented "new pressure areas" noted to left Achilles (back of ankle/heel) and left outer ankle "caused by foot brace." Cleanse with wound cleanser apply hydrocolloid dressing every 3 days. Apply padding between brace and shin. Continue to reposition every 2 hours. 11/11/16 (5:28 PM) - Progress note documented assessment of left foot wounds: left Achilles 2.4 cm x 1.6 cm and left lateral ankle 1.6 cm x 1.4 cm. NP contacted and orders obtained. Physical Therapy contacted and brace to not be used at this point. Heel protectors to be used until PT can order a different device. 11/14/16 - Blood test revealed low protein levels with albumin 2.1 (3.4-5.0) and prealbumin 21 (20-40). 11/14/16 - Progress note documented resident scheduled for special medical scan at 2:00 PM. [Resident would be on a stretcher for transportation and on the hard medical table during the test.] 11/17/16 - Care plan meeting (R186's wife, brother and mother attending). Summary included	F 314		

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F 314	Continued From page 31 wound care was being provided for a stage 2 buttock wound and that the elbow wound was in the healing process. Boots will be placed on feet for prevention of skin breakdown. "Turning schedule is now in place to have R186 turned on a more frequent basis." 11/17/16 (11:33 AM) - Change of Condition Note - Skin documented worsening of the buttock pressure area as slough covered the wound bed. Treatment changed to MediHoney to aid in removal of the slough. MD/wife notified. [The right buttock wound had become unstageable.] November, 2016 - Skin Integrity Report indicated the wounds (ankle, Achilles, buttock, elbow) were not assessed the week of November 22. The date of the 22nd was crossed off and the 28th was written instead on the Skin Integrity Report. December 2016 - NP Note on December 5 and 7 documented the buttock pressure injury ulcer was a Stage 2, when in fact it was unstageable on the 5th and Stage 4 on the 7th. 12/14/16 - Nutrition Assessment documented that pressure ulcers have declined since initial assessment. Some are beginning to heal per wound care nurse. At this time due to worsened pressure related wounds and high risk for continued breakdown, tube feeding to provide 2700 calories and 148 grams of protein. 12/29/16 - Physicians' order included to float heels, turn and reposition every 2 hours and document resident position (Right, Left) required with each turn. This appeared on the MAR for the nurse to record resident position.	F 314		

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F 314	Continued From page 32 January, 2017 - Skin Integrity Report documented the left lateral ankle was healed on 1/20/17 and the elbow and left Achilles wounds were healed on 1/25/17. 3/21/17 (10:40 AM) - During the staff interview during stage 1 with E4 (UM) when asked "Does the resident currently have one or more pressure ulcers?" E4 said yes but R186 "didn't have it on admission, he got it on the other unit so it was not under my watch." When asked what stage since the Skin Integrity Report flowsheet indicated unstageable even though the wound bed was 100% visible with granulation tissue. E4 proceeded to state that once the wound was unstageable, it could not be changed. When asked to rate the severity, E4 said she saw the buttock wound recently and it would be a Stage 3. During an interview with E7 on 3/24/17 at 12:30 PM, immediately following wound care observation, when asked about the staging of the wound E7 stated the wound was a Stage 4 when the slough was removed. When reviewing the Skin Integrity Report flowsheet which indicated the severity was unstageable, E7 said that "once it is that [unstageable] it can't be changed." Surveyor showed the information from wound staging Hints & Tips found in the facility's wound binder that documented "Until enough slough and/or eschar is removed to expose the base of the wound, the true depth and therefore category / stage, cannot be determined." Surveyor explained that once the slough of the resident's wound came off on 12/5/16 and the wound bed was 90% visible and should have been staged (given a severity number) at that time. Once the pressure ulcer is given a number, in this case a Stage 4, it is always that number. It would be a	F 314		

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F 314	Continued From page 33 healing stage 4 pressure ulcer. Instead the severity was listed as unstageable through the 3/21/17 assessment. E7 said "I don't know what I was thinking when I wrote that." When discussing prevention measures E7 stated they [facility] "could have started the low air loss mattress sooner, but he wouldn't have qualified since he had no wounds when he got here." During an interview with E2 (DON) on 3/24/17 at 1:00 PM E2 was informed about assessment issue of not changing the unstageable to an actual stage number when the wound bed was visible and commented that "it sounds like we need to do education." During an interview with E2 on 3/28/17 at 9:20 AM to discuss that the admitting nurse documented the incision on elbow and not the pressure ulcer, E2 said that education is needed, especially for the nurses admitting residents. During an interview with E7 on 3/28/17 at 9:30 AM to determine when R186 got the specialty air loss mattress, E7 said "when the buttock wound worsened." We didn't start when he had stage 2's because he wouldn't qualify. We asked family if he was on a special mattress at shock trauma but they didn't know. We don't even know the treatments he was getting there. These findings were reviewed with E1 (NHA) and E2 on 3/28/17 at 2:00 PM. During a telephone interveiw with E3 (RN) UM of the unit where R186 was initially admitted on 3/31/17 at 8:25 AM to request information about the care and initial orders about the left leg brace. E3 explained that the overlay mattress used is a	F 314		

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F 314	Continued From page 34 static air mattress. At 3:30 PM documents received from E3 included discharge summary from shock trauma which did not mention the brace used after surgical repair of a broken bone in the left lower leg. Progress notes between October 28, 2016 - November 10, 2016 did not identify the left leg brace nor the skin assessment beneath the brace.	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 315		5/19/17

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F 315	Continued From page 35 continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to provide appropriate treatment and services to restore as much normal bladder function as possible for one (R96) out of 39 sampled residents. The facility failed to establish an individualized toileting schedule that included R96's use of the urinal. R96 declined from a 59% rate of bladder incontinence in November 2016 to a 96% rate of bladder incontinence in February 2017. Findings include: Review of R96's clinical record revealed; 11/9/16 -11/11/16 - A three day voiding diary was performed on R96 to assess continence and voiding patterns. Staff documented R96 was incontinent of urine and dry not toileted, there were no documented episodes of continent urine/toileted. However review of the bladder incontinence reports for the same three days documented R96 was continent using a urinal twice, 11/10/16 day shift and 11/11/16 night shift. 11/16/16 - An admission MDS assessment, documented R96 as frequently incontinent, having 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during the 7 day review period. R96 was documented as having a BIM's score of	F 315	A. No corrective action can be accomplished for this resident, as resident no longer resides at this facility. B. The records of residents who are incontinent of bladder have been reviewed to ensure that appropriate treatment and services to restore as much normal bladder function as possible are provided. No corrective action was needed. C. A root cause analysis was conducted. The nurses failed to individualize careplans to include the use of toilet/urinal by incorporating assessment data.The Nursing Clinical Assistant will monitor weekly for changes in incontinence more than 3 episodes from the prior week. The Nursing Clinical Assistant will notify the unit manager/designee and a 3 day diary will be initiated. D. Residents who are incontinent of bladder will be monitored to ensure any changes in continence are identified 100% of the time (Attachment I). Records for these residents will be monitored for changes daily by the unit managers until 100% success is achieved over 3 consecutive evaluations. Then records for these residents will be monitored for changes three times each week until	

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F 315	Continued From page 36 11. R96 was an extensive assistance with two people needed for toileting. November 2016 - Review of R96's bladder incontinence report (documented by CNA's) revealed a 59% rate of bladder incontinence. R96's continent episodes were with the use of the urinal and toilet. 12/1/16 - R96's bladder incontinence care plan was intiated, then last updated on 1/11/17 and documented that R96 was "incontinent of urine and is unable to cognitively or physically participate in a retraining program due to changes in mobility and cognition." The care plan goal was to have incontinence care needs met. Approaches for R96's bladder incontinence care plan included use absorbent products as needed and utilize appropriate continent product, there was no intervention that included the use of a urinal or a scheduled toileting time. December 2016 - Review of Review of R96's bladder incontinence report revealed a 50% rate of bladder incontinence. R96's continent episodes were with the use of the urinal and toilet. January 2017 - Review of R96's bladder incontinence report revealed a 92% rate of bladder incontinence. R96 had four episodes of continence with use of the urinal. The facility failed to identify that R96 was becoming less continent of bladder. February 2017 - Review of R96's bladder incontinence report revealed a 96% rate of bladder incontinence.	F 315	100% success is achieved over 3 consecutive evaluations. Then records for these residents will be monitored for changes once a week until success is achieved over 3 consecutive evaluations. Then records for these residents will be monitored for changes one more time, one month later. If we are 100% successful with this audit, we will conclude that we have successfully addressed the problem.	

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F 315	Continued From page 37 2/8/17 - A 90 day MDS assessment, documented R96 as always incontinent during the 7 day review period, having no episodes of continent voiding. R96 was documented as having a BIM's score of 11. R96 was an extensive assistance with two people needed for toileting. 2/9/17 - A physician order was written to send R96 out to the ER for checking of placement of tube-feeding. R96 did not return to the facility. During an interview on 3/28/17 at 9:11 AM with E 3(RN) unit manager, it was confirmed that the facility did not implement interventions to restore bladder continence for R96 to his/her prior level of functioning. E3 reported that the facility was unaware of R96's decline in bladder function until his 2/8/17 MDS assessment. During an interview on 4/3/17 at 2:28 PM with E3 it was reported that R96 asked for the urinal, and that urinal use is typically not on the CNA information sheet, but mentioned during report. These findings were reviewed with E1 (NHA) and E2 [DON] on 3/28/17 at 2:00 PM.	F 315		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or	F 329		5/19/17

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F 329	Continued From page 38 (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the drug regimen was free from unnecessary drugs for three (R9, R152 and R42) out of 39 sampled residents by failing to identify adequate indication or monitoring. For R9 and R152, the facility did not identify or monitor for specific behaviors for a medication ordered for behaviors. For R42 the facility failed to monitor the the blood level for	F 329	A. The records for R9 and R152 include identification of and monitoring for specific behaviors for medication ordered. The medication of R42 that was to be monitored has been discontinued. B. Records for residents on psychotropic medications and Vitamin B12 have been reviewed to ensure that adequate monitoring is performed. No corrective	

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F 329	Continued From page 39 B12. Findings include: 1. Review of R9's clinical record revealed: 6/11/08 - Admission to facility with multiple diagnoses including depression and obsessive-compulsive disease. 8/3/16 - Physicians' orders included Depakote to be given twice a day for behaviors. Specific behaviors or diagnosis were not specified for this medication. October 2016 - March 2017 - Review of Behavior Monitoring and Interventions found the facility was monitoring behaviors (refusing to speak, uncooperative and agitating other residents) for three other medications and not the Depakote. During an interview with E4 (UM) on 3/24/17 at 12:05 PM to discuss behavior monitoring E4 stated that charting was by exception and confirmed that Depakote was not included on the current behavior monitoring sheet. During an interview with E2 (DON) on 3/27/17 around 1:30 PM after obtaining the behavior monitoring sheets from August, 2016 it was confirmed that Depakote had never been included for behavior monitoring. 2. Review of R152's clinical record revealed the following: 12/17/15 - Admission to facility with multiple diagnoses including cerebrovascular disease, anxiety and depression. Physicians' orders included: -8/19/16 Diazepam Tablet 2 MG Give 1 tablet by	F 329	action was needed. C. A root cause analysis was conducted. The Nurses need to specify medication related to behavior prescribed for on behavior flow sheet and lab tests for specific medications should be ordered with the medication.The nurses will be re-educated on monitoring indications and behaviors for psychotropic medications and blood level for Vitamin B12. (Attachments J and K). D. Residents who are on psychotropic medication or Vitamin B12 will be monitored to ensure that indications, behaviors, and blood levels are documented 100% of the time (Attachment L). Records for these residents will be monitored for documentation daily by the unit managers until 100% success is achieved over 3 consecutive evaluations. Then records for these residents will be monitored for documentation three times each week until 100% success is achieved over 3 consecutive evaluations. Then records for these residents will be monitored for documentation once a week until success is achieved over 3 consecutive evaluations. Then records for these residents will be monitored for documentation one more time, one month later. If we are 100% successful with this audit, we will conclude that we have successfully addressed the problem.	

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F 329	Continued From page 40 mouth every 8 hours as needed for anxiety -8/19/16 (Discontinued 3/8/17) Quetiapine Fumarate Tablet 50 MG Give 1 tablet by mouth two times a day for depression -8/19/16 Sertraline HCl Tablet Give 12.5 mg by mouth one time a day for depression -8/19/16 Melatonin Tablet 5 MG Give 1 tablet by mouth at bedtime for sleep -2/8/17 Diazepam Tablet 2 MG Give 2 mg by mouth at bedtime for anxiety/sleep aid -3/8/17 Quetiapine Fumarate Tablet 25 MG Give 1 tablet by mouth two times a day for depression September 2016 - February 2017: Review of Nursing Behavior Monitoring and Interventions found the facility was monitoring behaviors for only anxiety. March 2017: Review of Nursing Behavior Monitoring and Interventions found the facility was monitoring behaviors for anxiety, striking out and yelling out. December 2016 - March 2017: CNA documentation revealed behavior monitoring for socially inappropriate as evidenced by: yelling out for staff , taking off clothing, blankets, and throwing pillows in the floor and making false accusations against staff, but no monitoring for sleep habits, sadness/depression or tearfulness. Psychotherapeutic Medication Use Evaluation: -2/28/17 documented that the new order on 2/8/17 for Diazepam Tablet 2 MG at bedtime was indicated for behavior symptom increase. But, no description of what behaviors increased. -3/24/17 documented that there was a decrease in Quetiapine Fumarate on 3/8/17 (from 50 mg bid to 25 mg bid), but there is no documentation	F 329		

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F 329	Continued From page 41 for rationale for this decrease or how the effectiveness of these changes will be monitored. -no other documentation found in R152's medical record to support the above medication changes or how the effectiveness of these changes will be monitored. Review of R156's care plan includes: - "Resident is at risk for complications related to use of psychotropic drugs" with goal of "Resident will have the smallest most effective dose without side effects X 100 days". Interventions include "Complete behavior monitoring flow sheet" (but, does not mention specific behaviors to monitor). - "Resident exhibits distressed mood symptoms as evidenced by: sadness/depression, anxiety" with goal of "Resident should experience a restful sleep every night by the next review period." Interventions include: - Log incidents of anxiousness and tearfulness on Behavior Flow Sheet - Observe and record sleep habits - Observe for changes in mood (absence of emotion in resident action and facial expression), behavior, and overall functioning) and document - Observe for signs/symptoms of depression or anxiety - Monitor current medication regime During an interview with E14 (LPN, charge nurse) on 3/28/17 at 10:00 AM to discuss behavior monitoring, E14 stated that charting was by exception and confirmed prior to March 2017 nursing was only monitoring anxiety (not for sleep habits, sadness/depression or tearfulness). 3. Clinical Record Review for R42 and staff	F 329		

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F 329	Continued From page 42 interviews revealed the following: The Medication Regimen Review (MRR)- 12 month sheet showed that there were no pharmacist recommendations during the reviews completed on 9/27/16, 10/17/16, 11/29/16, and 12/29/16. and 2/15/17. The MRR sheet showed that the review completed on 1/16/17 had a check mark to see report for any noted irregularities and/or recommendations. In addition, the MRR sheet showed there were no pharmacist irregularies or recommendations for 2/15/17 and 3/15/17. During an interview with the surveyor on 3/23/17 at 2:45 PM, E2 (DON) stated that the January 2017 pharmacist review consultation report with irregularities and/or recommendations was not available and that he/she was not able to locate the report. E2 brought the surveyor a pharmacist review consultation report dated 3/23/17 which had just been generated and had the following comments "repeated recommendation from 1/16/17." Recommendation was to please consider monitoring the vitamin B12 level at this time and then annually. Recommendations were accepted by the physician/nurse practitioner. There were new physician's orders written on 3/23/17 to do vitamin B12 levels annually. The surveyor was unable to find any B12 levels on the current record. The laboratory (lab) slip for Vitamin B12 indicated the level was drawn on 3/24/17 and the results showed that the level was 2680 which was above the normal range of 193 to 986. On 3/27/17 at 10: 01 AM the surveyor interviewed	F 329		

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F 329	Continued From page 43 E2. E2 explained that the pharmacist reviews are done on a certain date and then the consulting entity sends the completed pharmacist review consult report to the facility and that takes at least a week. Nursing gets the consult and makes sure recommendations are sent to the physician. According to E2, the January 2017 pharmacist review consult report for R42 was found still in the physician's mailbox and had not been acted upon. E2 stated it was not acted upon by the physician until the surveyor asked about the report. E2 also checked the resident's lab results and there were no B12 labs available for the resident on the current record. During an interview with the surveyor on 3/28/17 at 11:18 AM, E3 (RN-UM) stated he/she had been made aware of the issue with the January 2017 pharmacist review consultation report for R42 not being acted upon by the physician until 3/23/17. E3 stated that R42's vitamin B12 oral medication was discontinued on 3/27/17 due to the B12 level being high. The above findings were discussed with E1 (NHA) and E2 at the exit conference on 3/28/17 at 2:00 PM.	F 329		
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by	F 353		5/19/17

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F 353	Continued From page 44 resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by:	F 353		

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F 353	Continued From page 45 Based on resident and staff interviews and a review of other facility submitted documentation, it was determined that the facility failed to have sufficient nursing staff to provide nursing and/or ensure that staffing levels for nursing were adequate to meet the needs of dependent residents. Residents, who wished to remain anonymous, expressed concerns during stage 1 of the survey, in resident council and expressed concerns through written grievance/concern forms, 7 since January 2017 and 3 in the last thirty days, about staffing and concerns have continued. Findings include: 2/6/17 - Resident council meeting minutes documented "Unit one, 7-3 shift short hall a CNA, not the full-time CNA, told a resident "quit ringing the bell I'll get to you when I can." 2/9/17 - The facility held an Inservice on "not responding to resident call bell in a professional manner." Review of resident grievance/concern forms from November 2016 to present revealed seven (12/23/16, 1/25/17,1/26/17 [two from two different residents] 3/3/17, 3/6/17,and 3/7/17), grievances related to call bell response times. During an interview on 3/21/17 at 10:31 AM A5 answered "no" when asked "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?" A5 then explained "sometimes we have to wait in the mornings." During an interview on 3/21/17 at 11:23 AM A4 answered "no" when asked "Do you feel there is enough staff available to make sure you get the	F 353	A. Sufficient nursing staffing levels to meet the needs of dependent residents has been provided. B. All residents have been provided sufficient nursing staffing levels to meet their individual needs. C. A root cause analysis was conducted. Call bells have not been answered in a timely manner. The nursing staff will be re-educated on the answering of Call Lights(Attachment M). D. Residents will have their call bells answered promptly 100% of the time (Attachment N). Answering of call bells will be evaluated on each nursing unit daily by the charge nurse/designee until 100% success is achieved over 3 consecutive evaluations of no reported resident grievance/concern. Then answering of call bells will be monitored on each nursing unit by the charge nurse/designee three times each week until 100% success is achieved over 3 consecutive evaluations of no reported resident grievance/concern. Then answering of call bells will be monitored on each nursing unit by the charge nurse/designee once a week until success is achieved over 3 consecutive evaluations of no reported resident grievance/concern. Then answering of the call bells will be monitored on each nursing unit by the charge nurse/designee one more time, one month later of no reported resident grievance/concern. If we are 100% successful with this audit, we will conclude that we have successfully addressed the problem.	

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F 353	Continued From page 46 care and assistance you need without having to wait a long time?" A4 then explained "not always 3 to 11 shift." During an interview on 3/22/17 at 9:46 AM A2 answered "no", when asked "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?". A2 then stated "they are short, I have wait too long, twenty minutes, weekends are awful but it happens on all shifts. I get up and got to the bathroom by myself, but I'm not supposed to go by myself." During an interview on 3/22/17 at 10:14 AM A3 answered "no", when asked "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?" A3 then stated "I don't think its right that when you have to use the bathroom they don't come even... and they act like its your fault ...they have you waiting 45 minutes." During an interview on 3/22/17 at 12:17 PM, A1 answered "no" when asked "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?". A1 then stated "one day I laid in my mess for 3 hours". During a follow up interview on 3/28/17 at 9:44 AM with A1 it was reported that the longest she waited for assistance was at least two hours and that concerns have been reported to E9 (SW). During a follow up interview on 3/28/17 at 9:53 AM with A3 it was reported that the longest wait time response to a call bell was "over half an hour". A3 reported having had an episode of	F 353		

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F 353	Continued From page 47 incontinence due to waiting and has reported the incident but does not recall to whom. During an interview on 3/28/17 at 9:57 AM with E3 (RN) unit manager it was reported that she received two grievances related to staffing concerns and the facility's response to expressed concerns about grievances was to conduct an inservice to staff about answering call bells and to educate residents about reasonable expectations of wait times and explained that thirty minutes would be too long. E3 stated that staffing concerns from residents concerning time times were a "continuous complaint". E3 confirmed that residents have had events as the result of waiting for staff and described an incident where a resident alleged that she had an incontinent episode as a result of waiting for staff. During an interview on 3/28/17 at 12:11 PM with E1 (NHA) it was confirmed that facility's overall response to grievances related to staffing was to perform a staff inservice. It was also reported that E1 gained responsibility of reviewing resident grievances in November of 2016. The facility failed to provide evidence that staffing was adequate to ensure residents call bells were answered in a timely fashion and that resident needs were met. These findings were reviewed with E 1 and E2 (DON) on 3/28/17 at 2:00 PM.	F 353		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review	F 428		5/19/17

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F 428	Continued From page 48 (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 428		

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F 428	Continued From page 49 (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews and a review of the clinical record, it was determined that the facility failed to ensure that the pharmacy review and/or physician acknowledgement process for recommendations / irregularities was consistently acted upon in a timely manner for two (R42 and R9) out of 39 sampled residents. For R42 the pharmacist review recommendations from January 16, 2017 to consider monitoring B12 level was not acknowledged or acted upon by the physician until brought to the attention of staff by the surveyor on 3/23/17. For R9 the pharmacist recommendation to discontinue a medication was not acted upon for two months. Findings included: Cross Reference F329 - Example 2 1. Clinical Record Review for R42 and staff interviews revealed the following: The Medication Regimen Review (MRR) - 12 month sheet showed that there were no pharmacist recommendations during the reviews completed on 9/27/16, 10/17/16, 11/29/16, and 12/29/16 and 2/15/17. The MRR sheet showed that the review completed on 1/16/17 had a check mark to see report for any noted irregularities and/or recommendations. In addition, the MRR sheet showed there were no pharmacist irregularities or recommendations for 2/15/17 and	F 428	A. The pharmacist recommendations for R9 and R42 were reviewed with the physicians and were followed. B. Pharmacist recommendations for all other residents have been reviewed with the physicians. The physician has addressed each recommendation. No corrective action was needed. C. A root cause analysis was conducted. There are untimely follow up on pharmacy recommendations. NPE/designee will educate the unit managers/designees, physicians and physician extenders on the new process: Unit Managers/designee will receive a copy of pharmacy recommendations to address and have physicians/extenders complete their response, then orders will be written by the licensed staff and recommendations given to the DON to determine the monthly pharmacy recommendations are completed and kept in a binder in the DON office. (Attachment O). D. All pharmacist recommendations will be monitored for physician receipt and response monthly by the unit managers until 100% success is achieved over 3 consecutive evaluations (Attachment P). Then pharmacist recommendations will	

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F 428	Continued From page 50 3/15/17. During an interview with the surveyor on 3/23/17 at 2:45 PM, E2 (DON) stated that the January 2017 pharmacist review consultation report with irregularities and/or recommendations was not available and that he/she was not able to locate the report. E2 brought the surveyor a pharmacist review consultation report dated 3/23/17 which had just been generated and had the following comments "repeated recommendation from 1/16/17. Recommendation was to please consider monitoring B12 level at this time and then annually. Recommendations were accepted by the physician/nurse practitioner. There were new physician's orders written on 3/23/17 to do a vitamin B12 level annually. The lab slip for Vitamin B12 indicated the level was drawn on 3/24/17 and the results showed that the level was 2680 (high) which was above the normal range of 193 to 986. On 3/27/17 at 10: 01 AM the surveyor interviewed E2. E2 explained that the pharmacist reviews are done on a certain date and then the consulting entity sends the completed pharmacist review consult report to the facility and that takes at least a week. Nursing gets the consult and makes sure recommendations are sent to the physician. According to E2, the January 2017 pharmacist review consult report for R42 was found still in the physician's mailbox and had not been acted upon. E2 stated it was not acted upon by the physician until the surveyor asked about the report. During an interview with the surveyor on 3/28/17	F 428	be monitored for physician receipt and response every other month until 100% success is achieved over 3 consecutive evaluations. Then pharmacist recommendations will be monitored for physician receipt and response once a quarter until success is achieved over 3 consecutive evaluations. Then pharmacist recommendations will be monitored for physician receipt and response one more time, one month later. If we are 100% successful with this audit, we will conclude that we have successfully addressed the problem.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085015	A. BUILDING _____ B. WING _____	03/28/2017

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F 428	Continued From page 51 at 11:18 AM, E3 (RN-UM) stated he/she had been made aware of the issue with the January 2017 pharmacist review consultation report for R42 not being acted upon by the physician until 3/23/17. E3 stated that R42's vitamin B12 oral medication was discontinued on 3/27/17 due to the B12 level being high. 2. Review of R9's clinical record revealed: 6/6/16 Medication Regimen Review - Irregularity recommendation to discontinue one of the medications for lowering cholesterol and to repeat blood testing in 4 weeks. The date the physician acted upon the irregularity and signed the form was 8/3/16, almost two months later. During an interview with E2 (DON) on 3/27/17 at 10:00 AM about the process for pharmacy irregularities, E2 said "I'm not sue why it's late, we usually try to get it within two weeks." E2 added that the date on top is when the review was completed, but since the papers are mailed to the facility, they are often received 1-2 weeks after the review date. The DON added "I've talked to them [medical] about being late." These findings were discussed with E1 (NHA) and E2 on 3/28/17 at 2:00 PM.	F 428		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting,	F 441		5/19/17

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F 441	Continued From page 52 investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 441		

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F 441	Continued From page 53 contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews it was determined that the facility failed to maintain an effective infection control program when the required two-step PPD testing for two (E12 and E13) out of 16 employees sampled was not completed. Findings include: Review of the personnel audit sheet completed 3/27/17 indicated that two employees did not receive the required two-step PPD testing. There was no evidence that E12 had any PPD testing and that E13 did not receive the second step PPD test. During an interview on 3/27/17 at 2:27 PM with E11 Human Resources Manager, it was confirmed that there was no evidence of a PPD test for E12 and no evidence of a second step PPD test for E13.	F 441	A. PPD testing for employees E12 and E13 has been completed. B. All employees files have been reviewed to ensure that PPD testing has been completed when applicable. No corrective action was needed. C. A root cause analysis was conducted. There is an inconsistent documentation of Employee PPD's. The Nurse Practice Educator and Human Resources Manager will be re-educated on the employee PPD policy.(Attachment Q). D. Records of new employees will be monitored to ensure that they have received PPD testing (when applicable) 100% of the time (Attachment R). Records for new employees will be monitored for documentation daily by the Human Resources Manager until 100% success is achieved over 3 consecutive	

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F 441	Continued From page 54 These findings were discussed with E1 (NHA) and E2 [DON] on 3/28/17 at 2:00 PM.	F 441	evaluations. Then records for new employees will be monitored for documentation three times each week until 100% success is achieved over 3 consecutive evaluations. Then records for new employees will be monitored for documentation once a week until success is achieved over 3 consecutive evaluations. Then records for new employees will be monitored for documentation one more time, one month later. If we are 100% successful with this audit, we will conclude that we have successfully addressed the problem.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Seaford Center

DATE SURVEY COMPLETED: March 28, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility from March 21, 2017 through March 28, 2017. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 110. The Stage 2 sample totaled 39 (thirty nine) residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed March 27, 2017, F157, F0272, F0278, F0279, F0281, F0309, F0315, F0329, F0353, F0428, F0441	3201.1.2 Please see POC for F157, F0272, F0278, F0279, F0281, F0309, F0315, F0329, F0353, F0428, F0441	5/19/17

Provider's Signature Doris Schoolmaster Title Administrator Date 4/28/17